Appendix F
Ad Hoc Committee on Minority Health

A report given in response to the *1999-2004 Texas State Health Plan* goal:

Goal 5: Reduce disparity in health status among all population groups and enhance their access to quality health care by developing a diverse and culturally competent workforce.

Objective 5.1: Develop a Diverse and Culturally Competent Health Workforce in Texas.

Report to the Statewide Health Coordinating Council

January 13, 2000

Texas Statewide Health Coordinating Council
Ad Hoc Committee on Minority Health
Member List

Karl Urban, M.P.Aff.
Chair and Texas Health and Human Services Commission Representative
Member, Statewide Health Coordinating Council

Adena Loston, Ph.D.
Co-Chair
President, San Jacinto College South Houston, Texas
Member, Texas Statewide Health Coordinating Council

Charles T. Ku, D.D.S.
Member, Texas Statewide Health Coordinating Council

Kevin H. McKinney, M.D.
Houston Medical Forum
Assistant Professor of Internal Medicine UTMB

Clemelia Richardson, M.S.W.-A.C.P.
Director of Behavioral Health Services
People and Partnership, Houston Texas

Darryl Williams, M.D.
Exec. Dir., TEXAS TECH AHEC
Texas Tech University Health Sciences Center at El Paso

John Nava, M.D.
Vice President
Mexican American Physicians Association, San Antonio

R.J. Dutton, Ph.D.
Director, Office of Border Health
Texas Department of Health

Janet Leubner, M.B.A.
Program Administrator
Center for Rural Health Initiatives

Lois Linn, Ph.D.
Provost Rio Grande Campus
El Paso Community College

Budge Mabry
Director
UT System Dental & Medical Application

Paula R. Mitchell, R.N.C., M.S.N., Ed.D.
Dean, Health Occupations
El Paso Community College

Staff

Renato Espinoza, Ph.D., M.P.H.
Researcher, Office of Policy and Planning

Gregg E. Ukaegbu, M.P.Admin.
Planner, Office of Policy and Planning

Ad Hoc Committee on Minority Health

INTRODUCTION

Despite advances in medicine, public health practice, and medical technology the health status of the different racial and ethnic groups have not experienced the same gains found in the health status of the Anglo population. Two strategies to address disparities are (1) increasing the representation of minority healthcare providers, and (2) enhancing the cultural competency of all providers. They should be part of a comprehensive longterm state and national effort to achieve the goal of reducing or eliminating the disparities in minority health status.

Texas State Health Plan 1999-2004

The Texas Statewide Health Coordinating Council identified and documented some of the health disparities found among the state's minority population in the *1997-1998 Texas State Health Plan Update.*[1] In the *1999-2004 Texas State Health Plan,* the Council sought to address the reduction of the disparities in minority health status by encouraging the development of a diverse and culturally competent health workforce in Texas. To that end, it set up an ad hoc committee on minority health to address Goal 5 of the *1999-2004 Texas State Health Plan*: **"Reduce disparity in health status among all population groups and enhance their access to quality health care by developing a diverse and culturally competent work force."** The ad hoc committee was charged to report its findings and recommendations to the Council by January 2000.[2]

The Ad Hoc Committee on Minority Health

The Ad Hoc Committee on Minority Health, which was made up of members of health professions, higher education, health education administrators, and a social work professional, decided to direct their efforts on the accomplishment of the following key elements of their charge:

- Develop goals and strategies for the recruitment and retention of minorities in health care professions and
- Propose standards for culturally competent health care practice and practitioners.

The committee focused their research on factors that affect the health status of minorities. They hosted a symposium on June 17, 1999, featuring presentations by experts on minority health, consumer testimonies and input, during a question and answer session. Topics covered in the symposium were:

- Recruitment and retention of minorities in the health workforce
- Programs/policies to increase minority representation in the health workforce
- Policy implications of Hopwood on the health workforce
- Medical schools' admission formulae
- AHEC efforts in the recruitment and retention of the under-represented and disadvantaged
- Strategies to reduce the disparities in minority health

The information from these sources increased the committee's confidence that the implementation of these two strategies can make a significant contribution to the improvement of the health status of minorities.

BACKGROUND

Overview Of Health Disparities In The Minority Population

Health Disparities in the Nation

Blacks, Hispanics, Asian and Pacific Islanders, and American Indians/Alaska Natives, (the U.S. recognized minority populations) have poorer health status compared to the majority population. As a group, they tend to experience lower life expectancy, have greater prevalence of chronic diseases, less than optimal outcomes for pregnancy, and a higher incidence of cardiovascular diseases.[3]

These disparities are illustrated on Table F-1, which shows selected examples of the higher incidence of certain illnesses and clinical conditions, including infant mortality, experienced by racial and ethnic populations in the nation.

As Table F-1 shows, clear disparities in age-adjusted mortality rates continue to exist for racial and ethnic minorities. Cancer and heart disease are particularly adverse for Blacks. Although Hispanics have better outcomes on those diseases, they suffer from a high diabetes death rate. Infant mortality rates are over two times higher for Blacks than for Whites. The death rate from HIV/Aids for Blacks in 1997 was three times that of Hispanics, and more than six times that of Whites for the same period.[4]

Table F-1. Age Adjusted Death Rates by Ethnicity in the U.S.

1997 Age Adjusted Death Rates for Selected Causes of Death per 100,000 Population United States			
Disease	**White**	**Black**	**Hispanic**
Cancer	122.9	165.2	76.4
Heart Disease	125.9	185.7	86.8
Diabetes	11.9	28.9	18.7
HIV/AIDS	3.3	24.9	8.2
Infant Mortality*	6.1	14.2	6.0

* Infant mortality per 1000 live births.
Sources: U.S. Department of Health and Human Services. Health. United States 1999.
National Vital Statistics Report, Vol.47, No.9, Nov.10, 1998
National Vital Statistics Report, Vol.47, No.19, 1999

There are many factors that impact minorities' access to health care, but even for those minorities that have access to the system of care, there are some indications the level of services they receive may be influenced by race and gender. Results of a controlled study published in 1999 by the *New England Journal of Medicine*, demonstrated clear biases in physician's recommendations for catheterization of patients of different race and sex who presented the same types of chest pain.[5]

The importance of issues related to minority health is reinforced in the U. S. Department of Health and Human Services document, *Healthy People 2010 Objectives: Draft for Public Comment*:

> Compelling evidence that race and ethnicity correlate with persistent, and often increasing, health disparities among U.S. populations demands national attention. Indeed, despite notable progress in the overall health of the Nation, there are continuing disparities in the burden of illness and death experienced by Blacks, Hispanics, American Indians and Alaska Natives, and Pacific Islanders, compared to the U.S. population as a whole. The demographic changes that are anticipated over the next decade magnify the importance of addressing disparities in health status.[6]

National Initiatives to Address Health Disparities

Following the 1997 Healthy People 2000 Review, federal leadership in the form of funding, technical assistance and research has been energized to increase attention to disparities. That report showed that there were more than 50 Healthy People 2000 objectives where one

or more racial/ethnic minority group experienced a 25 percent or more disparity with the HP 2000 target. Objectives include death rates from chronic diseases, such as coronary heart disease and stoke, various cancers and diabetes, death rates from intentional and unintentional injuries, maternal and child health indicators, such as infant and maternal deaths, low birth weight, complications of pregnancy, deaths, incidence and prevalence of preventable infectious diseases, as well as behavioral risk factors, such as cigarette smoking, drug and alcohol abuse, and others.[7]

The development of the new set of Healthy People 2010 Goals and Objectives has involved a large number of public and private national and state organizations and agencies, professional organizations, advocacy organizations and their membership in a consortium that has provided opportunities to participate in the process to thousands of dedicated people throughout the nation.[8]

In order to support meeting Goal 2, **"Eliminate Health Disparities"** of the Healthy People 2010 initiative, the Health Resources Services Administration (HRSA) plans to fund "Centers of Excellence" to focus on the study of causes and strategies for improving the health status of racial and ethnic minority populations in the country, and thus eliminate some of the sources of the health disparities.[9]

Within the framework of *Healthy People 2010 Objectives: Draft for Public Comment*, President Clinton committed the agencies under the department of Health and Human Services to increase their efforts towards eliminating disparities in the areas of infant mortality, cancer screening and management, cardiovascular disease, diabetes, HIV/AIDS, and childhood and adult immunizations by the year 2010.[10]

The Health Resources Services Administration's Bureau of Primary Health Care launched the "Campaign to Ensure Total Health Care Access and Eliminate Disparities." This initiative is envisioned to be a state-based community-driven health care campaign to ensure 100 percent access and zero percent disparities by organizing key groups and helping communities meet their health needs through partnerships with safety net providers. Organizations joining the campaign include the Robert Wood Johnson Foundation, the Community Development Corporation and the Coalition for Healthier Cities and Communities.[11]

Another major source of federal initiatives and special grant programs is the Centers for Disease Control and Prevention (CDC). The CDC has embraced the Healthy People 2010

Goals and Objectives and will be using them in their block funding to states to encourage special efforts by states and communities to address the disparities in the health status of minorities.

The Robert Wood Johnson Foundation and the Kaiser Family Foundation are major sources of private foundation resources and leadership in minority health issues. Their "Opening Doors" initiative addresses increasing access to health care for minorities and disadvantaged populations.[12]

Health disparities in Texas

These national efforts serve as the context for state-level initiatives such as that expressed in Goal 5 of the *1999-2004 Texas State Health Plan*, "*…to reduce disparity in the health care status and enhance their access to quality health care by developing a diverse and culturally competent workforce."*[13]

To a great extent, the health status of minorities in Texas mirrors that of the nation. Table F-2 presents the mortality rates for the same selected illnesses and clinical conditions as presented in national information. As shown, in 1997 in Texas the health outcomes of Blacks were consistently worse than those of Whites in all areas. Hispanics exceeded Whites in their diabetes and HIV/AIDS death rates.

Table F-2. Age Adjusted Death Rates by Ethnicity in Texas

1997 Age Adjusted Death Rates for Selected Causes of Death per 100,000 Population, Texas			
Disease	**White**	**Black**	**Hispanic**
Cancer	127.6	183.2	94.1
Heart Disease	144	219.2	118.4
Diabetes	12.4	35.2	32
HIV/AIDS	3.9	19.6	5.1
Infant Mortality*	5.8	10.9	6.0

* Infant Mortality is the number of infant deaths per 1000 live births.
Source: Texas Department of Health, Bureau of Vital Statistics.
Texas Vital Statistics 1997

Initiatives to Address Health Disparities in Texas

The Texas Department of Health is the principal source of state funding and initiatives to increase access to health care for disadvantaged and minority populations in Texas. The department works in close cooperation and partnership with other agencies, community organizations, professional associations, advocacy groups, foundations and businesses to advance the improvement of the well being of all Texans, including minorities and disadvantaged segments of the population.

The *1999-2003 Texas Department of Health Strategic Plan* addresses health disparities directly under its goals relating to Medicaid services, promoting equitable access and prevention and promotion.

The various Medicaid programs are provided to individuals who qualify on the basis of income. Therefore, they tend to serve a significantly higher proportion of minority clients, who are over-represented among the low-income population. Increasing this population's access to health care services is expected to improve health outcomes.

The implementation of the Children Health Insurance Program (CHIP), with state and federal funds, will provide many more children health insurance by including children living in families up to 200 percent of the federal poverty level. Access to preventive health care, screening, and immunizations for these children should result in better overall health, and increase protection against premature death.[14]

Under the Texas Department of Health goal to Promote Equitable Access, special efforts are made to develop community-based solutions to enhance access to primary care and preventive health services. By targeting disadvantaged communities and encouraging the involvement of a broad range of community agencies and organizations, these programs tend to reach a larger proportion of the minority population in those communities.[15]

One of the Texas Department of Health's Office of Minority Health (OMH) missions is to assist minority communities and organizations in the development and implementation of health care access solutions at the local level. This is done through training and technical assistance to community organizations and by supporting the development of minority health networks that can be effective partners with other local organizations. The OMH also works with programs within the Texas Department of Health and with other federal, state and

local agencies and organizations to coordinate and facilitate access to minority communities through its central office and minority health coordinators in four of the eight regions of the state.[16]

In addition to the Texas Department of Health, a number of state and local foundations provide support to programs designed to expand access to heath services to all minority and disadvantaged populations.

There are also several research and demonstration programs carried out by universities and health science centers funded by federal agencies, who seek to improve access of minority and disadvantaged populations, such as migrant workers and *colonia* residents to health services.

Developing a Diverse and Culturally Competent Workforce in Texas

The goal of the SHCC to reduce disparity in health status among all population groups and enhance their access to quality health care implies the pursuit of two distinct but mutually supportive strategies.

In support of both the diversity and the cultural competency strategies, Dr. Steve Murdock, Director of the Texas Data Center at Texas A & M University, states that:

> While it is not imperative that the racial/ethnic status of health care personnel mirror that of the patient population, there will be an increasing demand for the diversification of the health workforce in Texas. The broad ethnic diversity of Texas calls for a workforce that is, at best, an ethnic/cultural reflection of the population, and at least, well educated in the cultures, customs, and health beliefs of the major population segments it serves.[17]

Diversity in the workforce at the National Level

Leading the efforts for increasing the diversity of the nation's workforce, the Pew Health Professions Commission issued its fourth report in 1998 entitled "Recreating Professional Practice for a New Century." Their second recommendation, addressing all professional groups, was entitled "Ensure that the health professional workforce reflects the diversity of the nation's population." It reads:

> It is essential that the nation's health profession workforce represent the cultural diversity that is and will become even more significant part of this society. This is not a quota borne out of a sense of equity or distribution of justice, but a principle that the best health care is delivered by those that fully understand a cultural tradition. The next generation of health professionals should represent the nation. Not only would renewed commitment to diversity be the fairest way to accommodate all potential medical practitioners, it would be in the best interest of those parts of the population that bear the greatest burdens of poor health. Students that come from medically under-served communities have demonstrated a much greater willingness to return to them to practice. By knowing the language and mores of the population they serve, they offer a more complete and effective kind of care.[18]

Historically, Blacks and Hispanics have been under-represented in the health professional workforce. Recognizing the need to increase the numbers of minority professionals, in 1991 the American Association of Medical Colleges launched an initiative, "Project 3000 by 2000" as a commitment from mainstream institutions to recruit and train 3,000 minority physicians by the year 2000.[19]

Not much progress has been made since then. In an October 29, 1999 press release, the American Association of Medical Colleges reports that in 1999, the percentage of under-represented minority applicants to medical schools fell by almost seven percent to a low of 4,176 applicants. The number of total applicants and under-represented minority applicants represent the lowest figures since 1992.[20]

With respect to other health-related professions, the May/June 1999 newsletter published by the U.S. Department of Health and Human Services Office of Minority Health was devoted to the discussion of the disparate representation of minorities in the nation's health workforce. After examining data for a number of health-related professions and occupations, Kamat concludes that "…major discrepancies persist in the representation of racial and ethnic minorities within the Nation's health professions workforce."[21]

Data on the national level reviewed by Kamat show that Blacks, Hispanics, American Indians, and Alaskan Natives constitute ten percent of the nation's health workforce, compared to 25 percent of the total population.[22] Despite the variations among minorities in specific health professions, Blacks and Hispanics are greatly under-represented in professions that require extensive training such as medicine, dentistry, and pharmacy.[23]

However, they are only slightly under-represented in professions that require substantial formal academic training. In dietetics for instance, Blacks constitute 18.2 percent. They also make up 24 percent of the social workers, and are close to parity among psychologists relative to their percentage in the population.[24] That is not the case when it comes to orderlies and nurse aides, where Blacks are over-represented. Hispanics are relatively well represented as dental assistants, and medical appliance technicians, but are not as well represented in professions that require higher level academic education.

In 1998, the Council on Graduate Medical Education, in its report *Minorities in Medicine*,[25] cited findings of studies that support increasing the number of minorities in the health workforce to reduce health disparities. In part, findings show that:

- Black and Hispanic physicians tended to practice in areas with high percentage of Black and Hispanic residents.
- Black physicians cared for more patients covered by Medicaid, and Hispanic physicians cared for more uninsured patients.

It is clear that minority physicians make an important and unique contribution by providing minorities and disadvantaged patients increased access to culturally competent health care services.

National data on current student enrollment in selected health professions does not suggest that a correction of the under-representation is under way. National enrollment into medical schools show a rising trend of minority enrollment in allopathic medical schools from 1950 to 1995. However, enrollment declined in 1996 and 1997 for all minorities except Asian Americans.[26]

In an October 29, 1999 press release,[27] the Association of American Medical Colleges (AAMC) reports that overall, the applicant pool for U.S. medical schools declined for the third straight year to 38,534, a drop of six percent. In 1996, the number of applicants to medical school reached an all time high of nearly 47,000. Despite the fluctuation in the number of applicants, the number of matriculating first-year medical students has remained roughly the same over the past 20 years. In 1999, 16,221 individuals entered medical school. In 1999, the percentage of under-represented minority applicants fell by seven percent to a low of 4,176 applicants. The number of total applicants and under-represented minority

applicants represent the lowest figures since 1992. Dr. Jordan J. Cohen, MD, President of the AAMC, summarizes the findings:

> Despite the medical community's efforts to encourage minorities to pursue careers in medicine and the growing need for a diverse physician workforce, the numbers continue to decline. The AAMC and others must redouble their efforts to curtail this downward trend.[28]

Minority enrollment in other health professions schools is still relatively low. Kamat concludes his analysis of national data on a larger number of health professions by stating that, "...no health profession can boast Black, Hispanic, or American Indian/Alaska Native enrollment at parity with the U.S. population".[29]

The Pew Health Professions Commission fourth report issued in 1998 proposes that to create a diverse workforce, the following actions must be taken:

- Admissions policies in professional schools must supplement their academic standard for entry with other criteria for admission, such as ethnicity, cross-cultural experience and commitment to community service.
- Universities and academic health centers should actively engage the broader K-12 educational system to provide exposure to the sciences and health professions to populations who are under-represented in those fields.[30]

By following these recommended actions, it will be possible to improve admission policies, and improve the inadequacies in pre-college preparation in mathematics and the sciences,[31] and reverse the generally weaker academic preparation for the rigors of professional studies that minority children receive from elementary to high schools,[32] and decrease the higher minority drop out rates[33] from the health professions development pipeline. Without such actions, a reversal of these trends is unlikely.

Diversity in Texas Health Professionals

Two health professions are examples of the under-representation of minorities in the Texas health workforce. In Tables F-3 and F-4, primary care physicians and nurses illustrate the disparities in the representation of minority professionals in the current Texas healthcare workforce.

Table F-3. Population and White, Black and Hispanic Physicians as Percent of Total Number of Physicians for 1998[1]

Race\Ethnicity	1998 Population	% of 1998 Population	% of 1998 Physicians
White	10,966,761	56.9	68.9
Black	2,249,537	11.5	3.8
Hispanic	5,870,804	29.9	12.2
Total	19,649,800		

(1) Data provided by the Health Professions Resource Center

Table F-4. Population and White, Black, and Hispanic Nurses as Percent a of Total Number of Nurses for 1998 [1]

Race\Ethnicity	1998 Population	% of 1998 Population	% of 1998 Nurses
White	10,966,761	56.9	80.1
Black	2,249,537	11.5	6.2
Hispanic	5,870,804	29.9	6.3
Total population 1998	19,649,800		

(1) Data provided by the Health Professions Resource Center

In 1998 Blacks constituted 11.5 percent of the population of the state, but were only 3.8 percent of all primary care doctors. In 1998 the Hispanic population in the state was 29.9 percent, while Hispanic primary care doctors constituted only 12.2 percent of all doctors. Similar patterns as those of primary care physicians are found in data available for Texas nurses. In 1998 the Black population was 11.4 percent of the total population, and Black nurses were only 6.2 percent of the total number of nurses registered in the state. For Hispanic nurses, the gap is even greater. In 1998 Hispanics were 29.9 percent of the total population, whereas Hispanic nurses were only 6.3 percent of the total nurses in the state.

In Texas, there was a dramatic decline in minority enrollment in medical schools following the *Hopwood* decision by the Fifth Court of Appeals in 1997, which eliminated race and ethnicity considerations in the admission to higher education professional schools in Texas. It also coincided with the voter approval of Proposition 209 in California, which generally prohibited discrimination or preferential treatment based on race, sex, color, ethnicity, or national origin in public employment, education, and contracting.[34]

A 1998 report from the Texas Higher Education Coordinating Board states:

> Generally, the 1998 application and offers data show a slight rebound in minority participation from the significant declines in 1997 but there are still problems. [Medical] Institutions are working to adjust their admissions and recruitment processes to increase the numbers; however, their success has been limited.[35]

Texas higher education institutions have made efforts to increase the number of minority professionals to correct the current under-representation of racial\ethnic minorities, in particular Blacks and Hispanics in the health professions, especially in Medicine, a profession that requires longer years of study.[36]

Almost all Texas medical colleges have programs designed to encourage under-represented minority students pursuing careers in medicine and the health professions. These programs are very similar in the strategies used at various levels in the "educational pipeline" that leads from secondary school graduation to application and entrance into professional schools. They target minority students by exposing them to the health professions, and by providing or strengthening the requisite skills necessary for success at each stage of the pipeline. For example:

- Texas A&M University's Bridge to Medicine MCAT Program (BTM) for disadvantaged college students offers participants an intensive academic study program designed to reinforce knowledge in Biology, General and Organic Chemistry, Physics, and Mathematics. The program also enhances critical study skills and further develops skills in reading and writing. Under the instruction of Texas A&M University faculty, students will build on their knowledge and strengths, and refine their test-taking skills in preparation for the Medical College Admissions Test (MCAT).
- A Summer Medical Enrichment Program was developed at Texas A&M to increase the number of high school students interested in the health professions. Students currently enrolled in their sophomore or junior year of high school are provided the opportunity to participate in a one-week summer enrichment program visiting the Texas A&M University System Health Science Center, College of Medicine.
- The University of North Texas has pipeline programs which begin with K-12 programs for elementary through high school, and continues for college students preparing for medical or biomedical research careers, and culminates in programs

for graduate students entering studies for the doctoral degree. The school also participates in Health Careers Opportunity Program (HCOP) and Summer Multi-cultural Advanced Research (SMART).

- The University of Texas Medical Branch in Galveston has a well-developed medical school familiarization program, recognized as a model nationwide. It is designed to provide disadvantaged undergraduates a realistic experience in the requirements of medical, dental, and allied health sciences. Funded by the U.S. Department of Health & Human Services under the Health Careers Opportunity Program (HCOP), the program seeks to build diversity in the healthcare fields through a series of integrated programs collectively known as Strategies & Techniques Applied to Recruit & Retain Students (STARRS). The activities of the six programs within the STARRS Project provide students from disadvantaged backgrounds the opportunity to enhance their academic skills and the support needed to successfully compete, matriculate, graduate and ultimately go on to rewarding careers in the health care industry.[37]

Outside the universities, but working in close cooperation with them, the network of Texas Area Health Education Centers (AHEC's) and Dr. Mario Ramirez working in South Texas have been exemplary in directing minority youth interest to the health professions.

- The East Texas AHEC's Health Careers Promotion program provides high school students the knowledge, skills and experiences to make informed choices about entering health careers.
- Dr. Mario Ramirez's MED ED program uses workshops, mentors, seminars, intensive skills acquisition and improvement summer camps to fortify high school students' interest in the health careers.
- The Health Science Technology program of the Texas Education Agency offers a comprehensive curriculum with the objective of attracting high school students into the health professions.
- The federally funded Health Careers Opportunities Program (HCOP) is one of the major providers of support for programs in the Allied Health Professions, which tend to be located in four-year and community colleges. HCOP programs provide summer institutes to recruit and prepare high school graduates for admission and completion of a variety of allied health professions. Some programs allow community college students to transfer to four-year baccalaureate degree programs and then to graduate schools. The student population at community colleges tends to be more diverse in terms of race and ethnicity, and to contain a large proportion of adults.

Increasing the numbers and proportions of under-represented minorities in the health professions will increase the supply of health providers and practitioners who share cultural knowledge, including a common language with their patients can use their awareness of the cultural dynamics of the patients they serve to provide quality services.[38]

The ad hoc committee believed that these examples provide models of successful experiences that should be supported because it is critical to support students as early as possible in the education pipeline to develop the academic skills necessary for health professions study.

The recommendations section of this document presents some specific strategies that can be pursued and programs that can be implemented and expanded to meet the challenges set forth by this component of the overall charge to the SHCC Committee on Minority Health.

Achieving Culturally Competent
Health Care Practice and Practitioners

Another strategy proposed to help reduce the disparities in minority health is to develop more culturally competent delivery systems and workforce. The members of the ad hoc committee believed that the concept of cultural competency is important to address health disparities. The members also believed that the term can be misleading because the term "competency" could be interpreted as implying that there is a base knowledge to be learned that makes a professional culturally competent. As the following discussion of the concepts underlying cultural competency indicates, cultural competency is related to attitudes and approaches to the delivery of health services as much as specific knowledge and abilities, such as a different language.

Concepts

Cultural competence is defined as "…a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among health professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations."[39] Operationally defined, cultural competency is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices and attitudes used in appropriate cultural settings to increase the quality of services; thereby producing better outcomes.[40] Cultural competency is more than the linguistic ability to speak another language, or to understand and be understood by others. It involves listening and learning; emphasizing attitudes such as respect; values, such as acceptance of differences; and behaviors that convey the desire and willingness to help and serve everyone, regardless

of language, color, or ability to pay.[41] The word *culture* is used because it implies the integrated patterns of human behavior that includes thoughts, communications, actions, customs, beliefs, values and institutions of racial, ethnic, religious or social groups.[42] Cultural knowledge is only one component of cultural competency; it refers to familiarization with selected cultural characteristics, history, values, belief systems and behaviors of the members of another ethnic group.[43] Being competent in cross-cultural functioning means learning new patterns of behavior and applying them in the appropriate settings.[44] Valuing diversity means accepting and respecting differences. People come from very different backgrounds, and their customs, thoughts, ways of communicating, values, traditions and institutions vary accordingly.[45]

Cultural competency promotes an atmosphere conducive for optimum patient/provider relationships. Furthermore, a culturally competent workforce can reduce some of the communications barriers that impair practitioner/patient interpersonal relationships, as well as the understanding of each others' messages and assumptions, which often results in negative outcomes such as misdiagnoses, unnecessary diagnostic tests, practitioner frustration, patient dissatisfaction, and poor compliance with post treatment instructions.[46]

Strategies

The American Medical Association has stressed the need for a culturally competent health workforce to meet the health needs of diverse people within the nation.[47] The Pew Health Professions Commission agreed in their third report with the substantial body of literature which contends that "culturally sensitive care is good care". Following that assertion, they recommended that health professional schools must ensure that the students they train reflect the ethnic diversity of the society, and make cultural sensitivity a part of every student's educational experience.[48]

The National Center for Cultural Competence, a national leader in the development of training materials and guidelines for implementing cultural competency in the health and human services, provides further elaboration on the impact of culture on the quality of health care.

The following patient-provider issues substantiate the need for primary health care organizations to develop policies, structures, practices and procedures to support the delivery of culturally and linguistic competent services to all patients:

- The perception of illness and disease and their causes varies by culture.
- Diverse belief systems exist related to health, healing and wellness.
- Culture influences help seeking behaviors and attitudes toward health care agencies and providers.
- Individual preferences affect traditional and non-traditional approaches to health care.
- Patients must overcome personal experiences of biases within health care systems.
- Health care providers from culturally and linguistically diverse groups are under-represented in the current health services delivery system.

The National Center on Cultural Competency proposes that cultural competency is a necessity for all health providers, but in particular for health personnel who provide primary health care and prevention services in clinical settings. The following are compelling reasons for striving to achieve cultural competency at the individual and organizational levels:

- To respond to the current diversity of the population and the demographic changes that have been forecast for the U.S. in terms of net growth of the minority populations in number and as a proportion of the total population.
- To eliminate long-standing disparities in the health status of people of diverse racial, ethnic and cultural backgrounds.
- To improve the quality of services and health outcomes.
- To meet legislative, regulatory and accreditation mandates.
- To gain a competitive edge in the market place.
- To decrease the likelihood of liability/malpractice claims.

The conceptual framework of the cultural competence model used by the National Center on Cultural Competency is based on the following beliefs:

- There is a defined set of values, principles, structures, attitudes and practices inherent in a culturally competent system of care;
- Cultural competence at both the organizational and individual level is an ongoing developmental process; and
- Cultural competency must be systematically incorporated at every level of an organization, including the policy-making, administrative, practice and consumer/family levels.

The National Center on Cultural Competency has developed and published several tools and guidelines to assist organizations and individuals in their self-assessment to determine where they are in a continuum of cultural competency.[49]

Finally, the Pew Health Professions Commission,[50] in their Fourth Report on Recreating Health Professional Practice, writes:

> America's population is becoming increasingly diverse as we move towards the 21st Century. During the course of their careers, practitioners should go out of their way to encounter individuals and communities whose values and beliefs about health and health care differ from their own. To provide effective care, health practitioners must understand how culturally learned values and customs affect people's health beliefs and practices. Such practices might include the use of non-traditional, alternative and complementary therapies. It may also give the caregiver reason to study and master a foreign language. Health professionals must use their knowledge to collaborate with individuals and communities to provide health care that is sensitive to and consistent with cultural values, beliefs and customs.

Texas Initiatives

In 1992, the Texas Department of Health received a Special Programs of Regional and National Significance (SPRANS) grant to establish the Maternal\Child Health National Resource Center on Cultural Competency (MCH/NRCCC). Until 1998, the MCH/NRCCC operated a 12-state consortium that provided training and technical assistance, developed assessment tools, and published a diversity curriculum for use in schools of social work, with plans to adapt it for expanded use by other professional schools.

To meet the needs of the current workforce, the (MCH/NRCCC) developed a curriculum to conduct cultural competency self-assessments on demand to programs and other state agencies. After the end of the MCH grant in 1998, work has continued in Texas by Texas Department of Health's Texas Center on Cultural Competency, which has conducted numerous cultural competency assessments for TDH programs and other agencies, and has followed up with training based on those assessments.

In 1997-98 The Texas Center on Cultural Competency assisted the Bureau of Medicaid/ Managed Care to incorporate guidelines and standards for cultural and linguistic competence into the contracts for the implementation of the Medicaid/Managed Care expansion beyond the initial pilot sites.

In 1998 TDH's Bureau of HIV\STD, using federal funding and with assistance from the Texas Center on Cultural Competency initiated the development and implementation of a comprehensive system of cultural competency training for all of their outreach workers and contractors. A product from this work is a well-developed cultural competency curriculum and a core staff qualified to conduct "train-the-trainer" workshops to expand the reach of cultural competency training to new workers throughout the state.

The information presented supports a strategy for increasing the cultural competency of both agencies and of all members of the current workforce. This strategy recognizes that most care will take place in multi-cultural settings where it is not always possible to match a patient with a provider of the same race or ethnicity. No group or professional category should be singled out for special training. The models used by both the National Center on Cultural Competence and the Texas Center for Cultural Competency start with an agency self-assessment, which includes the identification of their own human resources and those of the community they serve.

Summary

All of the programs mentioned in the section on diversity indicate that there are already substantial efforts to expand the diversity of the state's health care work force. Efforts to improve the cultural competency of the current work force have been centered on the public health work force and to some extent to the health care workforce in HMO's who provide Medicaid services under contract with the Texas Department of Health. However, it is also clear that these efforts have not been sufficient to meet the needs of the present, much less those of the future.

The most accepted scenario predicts that the Texas population will nearly double by 2030 from the 1990 baseline of about 17 million to about 34 million by 2030. By 2008, no ethnic group will account for more than 50 percent of the entire Texas population. The minority population will propel the expected growth, accounting for 87.5 percent of the total increase. Hispanics will increase by 258 percent from the 1990 baseline; Blacks will increase by 62 percent, while Anglos will experience a 20.4 percent of the net increase.[51] By 2030, minorities will constitute the majority in Texas population.[52]

Although it has been found that minorities tend to choose a provider of their own racial and ethnic group,[53] the reality in most health care settings is that neither clients nor providers

may have that choice. Therefore, cultural competency will be expected from all health providers and agencies.

At the very least, a diverse and culturally competent health workforce can increase the quality of care through promoting and supporting the attitudes, behaviors, knowledge and skills that are needed to work respectfully and effectively with patients of diverse cultures.[54] This kind of workforce will be instrumental in helping to decrease the disparities in minority health.

The reality of the disparities in minority health status has been well documented. The incentives for immediate action and solution to the issues of minority health in Texas can be found in the above projections about the state's demographic future, current health status of minorities within the state, and expected pressures of a larger and more diverse population on our health care system in terms of cost, availability, and quality. To meet these challenges, we need to improve our health care human resources through the recruitment and retention of minorities, and by assuring the cultural competency for all health care providers.

As has been documented earlier, health experts have placed much confidence in the recruitment and retention of minorities into the health professions, and in enhancing the cultural competency of the health workforce as appropriate policy options for addressing the generally poor health status of minority populations. The SHCC Ad Hoc Committee on Minority Health believes that this is a course of action that will be beneficial to the state of Texas based on the documentation presented.

The objective of these strategies is not to have health professionals of one ethnicity serving only patients of the same ethnicity, rather they should be part of a comprehensive public health strategy aimed at making significant progress in the improvement of the health status of not only minority populations, but that of all Texans. They are not a panacea, but promising solutions to a pervasive problem. The committee based its decisions on their meetings, a public symposium, research, and input from various sources throughout the state and the nation. The Committee submits the following recommendations:

AD HOC COMMITTEE RECOMMENDATIONS

Recommendation One: Improve the teaching of mathematics and science knowledge and skills to students in all stages of the education pipeline in order to better prepare them for health careers.

A. Increase funding for the development, and/or enhancement of remedial and enrichment programs that have proven successful in helping students at the elementary, secondary, and higher education levels succeed in school. Emphasis should be placed on funding institutions that have historically served minority populations.
B. Develop cooperative partnerships with Independent School Districts and the Texas Education Agency for the development and of faculty, curriculum and intervention strategies to improve the teaching of mathematics and sciences at the elementary and secondary school level to ensure that Texas' children have the knowledge and skills to succeed academically at the community college or university level.
C. Evaluate the effectiveness of minority recruitment and retention programs. Degree completion, licensure/certification, and job placement should be tracked as measures of success.

Recommendation Two: Increase funding for loans, grants, scholarships, and fellowships to assist minority and disadvantaged students seeking degrees in the health professions. Academic Health Centers, Area Health Education Centers, Community Colleges, and health professions associations should plan, implement and strengthen programs to meet Healthy People 2010 goals and strategies for increasing the numbers of minorities in health professions.

Recommendation Three: Provide training and continuing professional education in cultural competency and include practice opportunities that foster and support attitudes, behaviors, and skills necessary to work effectively and respectfully with patients of diverse cultures.

Recommendation Four: Fund the Texas Department of Health's Office of Minority Health to review the Healthy People 2010 goals and strategies related to reducing disparities

in health status in minority populations and promote and coordinate efforts for their adoption by programs within the Texas Department of Health and programs at other Health and Human Service agencies and other private and public organizations.

End Notes

1. Texas Statewide Health Coordinating Council. *Texas State Health Plan Update*; Texas Department of Health, Austin, 1996.

2. Texas Statewide Health Coordinating Council, *1999-2004 Texas State Health Plan: Ensuring a Quality Healthcare Workforce for Texas*, Texas Department of Health, Austin, 1998.

3. Levine, D.M., et al., "Community-Academic Health Center Partnerships for Underserved Minority Populations: One Solution to a National Crisis," *Journal of the American Medical Association*, 1994, 272: 4.

4. National Center for Health Statistics. Health, United States, 1999 with Health and Aging Chartbook (D.H.H.S. Pub. No. PHS) 99-1232. Hyattsville, Maryland: 1999.

5. Schulman, Kevin A., et al., "The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization." *The New England Journal of Medicine*, 1999, 340: 8.

6. U.S. Department of Health and Human Services, *Healthy People 2010 Objectives: Draft for Public Comment*. Washington D.C.: G.P.O., 1998.

7. Ibid

8. Ibid

9. HRSA Press Release, October 23, 1999.

10. U.S. Department of Health and Human Services, *Healthy People 2010 Objectives: Draft for Public Comment*. Washington D.C.: G.P.O., 1998.

11. HRSA Press Release, February 18, 1999.

12. Robert Wood Johnson Foundation and the Henry J. Kaiser Family Foundation. *Opening Doors: Reducing Socio-cultural Barriers to Health Care Initiative*. Washington D.C. 1997

13. Texas Statewide Health Coordinating Council, *1999-2004 Texas Statewide Plan: Ensuring a Quality Healthcare Workforce for Texas*, Texas Department of Health, Austin, 1998.

14. Texas Department of Health, "Public Health: Everyone, Everyday, Everywhere." *1999-2003 Strategic Plan*, 1998.

15. Ibid.

16. Texas Department of Health, Office of Minority Health, *Minority Health Brochure*. Austin, Texas, 1998.

17. Murdock, Steve H., et al. *Texas Challenge: Population Change and the Future of Texas*. Texas A&M University Press: College Station, 1996.

18. Ibid

19. Nickens, Herbert and Timothy Ready, "Project 3000 by 2000: Expanding Our Network", *Closing the Gap*, Office of Minority Health Resource Center, U.S. Department of Health and Human Services, May/June 1999.

20. AAMC Press Release, October 26, 1999.

21. Kamat, Miguel R., "Educating Health Professionals: Are We Failing Minorities?" *Closing the Gap*, U.S. Department of Health and Human Services, Office of Minority Health Resource Center. May/June 1999.

22. Kamat, Miguel R., op cit.

23. Ibid.

24. Ibid.

25. U.S. Department of Health and Human Services, 1998 Council on Graduate Medical Education, *Twelfth Report: Minorities in Medicine*.

26. Kamat, Miguel R., op cit.

27. AAMC Press Release, October 26, 1999.

28. Ibid.

29. Kamat, Miguel R., op cit.

30. Pew Health Professions Commission, *Fourth Report: Recreating Health Professional Practice for a New Century*, San Francisco, California, December 1998.

31. Girotti, Jorge A, "The Urban Health Program to Encourage Minority Enrollment at the University of Illinois at Chicago College of Medicine." *Academic Medicine*, 1999, 74: 4.

32. Wilson, John E., and Lucy Murphy, 1999. "Premedical and Predental Enrichment Program for Minority Students, 1969-1996 at Meharry Medical College," *Academic Medicine*, April 1999, 74: 4, 88-91.

33. Lewis, Cynthia, "A State University's Model Program to Increase the Number of Its Disadvantaged Students Who Matriculate into Health Professions Schools," *Academic Medicine*, 1996, 71:10

34. Nickens, Herbert, op cit.

35. Texas Higher Education Coordinating Board, Office of Access and Equity. *Report on the Effects of the Hopwood Decision on Minority Applications, Offers, and Enrollments at Public Institutions of Higher Education in Texas*. Austin, Texas, 1998.

36. Texas Medical Association, *The Physician Workforce in Texas: Implications for Medical Education*. Austin, Texas, 1999.

37. University of Texas Medical Branch at Galveston, *Starrs: Health Careers Opportunity Programs*. Available online: http://www.sahs.utmb.edu/studentaffairs/ hcopstarrs/ cophome.html, Accessed: December 10, 1999.

38. American College of Obstetricians and Gynecologists, *ACOG Committee Opinion: Cultural Competency in Health Care*, Vol. 62, 1998.

39. Cross, et al., *Towards a culturally competent system of care*, Volume 1. Washington, D.C., Georgetown University, Child Development Center, CASSP Technical Assistance Center, 1989

40. Davies, K., *Exploring the intersection between cultural competency and managed behavioral health care policy: Implications for state and county mental health agencies.* Alexandria, VA: National Technical Assistance Center for State Mental Health Planning, 1997.

41. Office of Minority Health, U.S. Department of Health and Human Services, *Cultural and Linguistic Competence Standards and Research Agenda Project*. Available online: http://www.omhrc.gov/WhatsNew/cultural1.htm. Accessed, December 10, 1999.

42. King, Mark A., et al., "How is Cultural Competence Integrated in Education." CECP Web page.

43. Ibid.

44. Ibid.

45. Ibid.

46. Woloshin, Steven, et al., "Language Barriers in Medicine in the United States," *Journal of the American Medical Association*, 1995, 273: 9.

47. American Medical Association, *Cultural Competency Compendium: Racial and Ethnic Disparities in Health Care*, 1999.

48. Ibid.

49. Georgetown University Child Development Center: National Center for Cultural Competence, *Getting Started… Planning, Implementing and Evaluating Culturally Competent Service Delivery Systems in Primary Health Care Settings*. Available online: http://www.dml.georgetown.edu/depts/pediatrics/gucdc/nccc8.html. Accessed October 15, 1999.

50. Pew Health Professions Commission, *Fourth Report: Recreating Health Professional Practice for a New Century*, December 1998.

51. Murdock, Steve H., op cit.

52. Archer, William R., Commissioner, Texas Department of Health, Presentation before the Texas Board of Health, October 14, 1999, Austin, Texas.

53. Komaromy, et al., "The Role of Black and Hispanic Physicians in Providing Health Care for Under-Served Populations," *The New England Journal of Medicine*, 1996, 334:20.

54. Ibid.